

October 7, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt,

On behalf of the nearly 30 million Americans with diabetes and the 86 million more with prediabetes, the American Diabetes Association (Association) appreciates the opportunity to submit comments on the Kentucky HEALTH Medicaid Section 1115 waiver proposal.

Adults with diabetes are disproportionately covered by Medicaid.¹ In Kentucky, over 11% of all adults have diabetes,² while 18% of adult Medicaid members have diabetes.³ Further, 15% of Kentuckians earning \$15,000 or less per year (125% of the federal poverty level (FPL) and below) have diabetes compared to 11% earning between \$25,000 and \$35,000 (210% FPL - 295% FPL), and 6.8% of those earning \$50,000 or more annually (over 420% FPL).⁴ Throughout the state, 289,000 adults have been diagnosed with prediabetes.⁵ According to the Centers for Disease Control and Prevention, almost 28% of people with diabetes nationwide are undiagnosed, and 90% of people with prediabetes do not know they have it.⁶

Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, racial and ethnic differences in morbidity and mortality from preventable and treatable conditions. For example, a study conducted in California found “amputation rates varied tenfold between the highest- and lowest-income neighborhoods in the state.”⁷ Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing these disparities. As such, the Association strongly supports Kentucky’s decision to continue to accept federal Medicaid funding to extend eligibility for the program. We do, however, have concerns regarding some of the provisions of the Kentucky HEALTH proposal, and provide the following comments and recommendations to help ensure the needs of low-income individuals with diabetes continue to be met by Kentucky’s Medicaid program.

Kentucky HEALTH Cost-Sharing

In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a study conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of \$10 per month is associated with a

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Diabetes Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.⁸ In addition, a Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that “[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes.”⁹ The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program.

The Kentucky HEALTH program proposes to require most participants to pay a monthly premium, regardless of their income level. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death. The Association is pleased Kentucky modified their waiver application to exempt those deemed medically frail from the monthly premium payments, but we seek additional information regarding the “optional” premium payments for this population. The state’s waiver application says premium payments are required for access to a member’s My Reward Account. But since the medically frail population will receive state plan benefits, which includes dental and vision care services, it’s not clear what benefits this population can receive from the My Reward Account. **The Association urges the Centers for Medicare and Medicaid Services (CMS) to work closely with the state regarding education and choice counseling for the medically frail population to ensure they fully understand their options.**

We also remain concerned by the level of cost-sharing required for the rest of the program enrollees—particularly those earning under the poverty level. **We encourage CMS to ensure these cost-sharing requirements do not act as a barrier to enrolling in and maintaining coverage under the program.**

The Kentucky HEALTH Program “Incentives” Discriminate Against Enrollees with Diabetes

The Association is highly concerned about the financial “incentives” included in the waiver proposal. The Kentucky HEALTH program will include a \$1,000 deductible, which will be funded by the state through a deductible account. Program enrollees will use funds from this account to pay for needed medical care until they have exhausted the deductible amount. The Kentucky HEALTH waiver proposal notes this deductible account will “provide financial incentives to prudently manage the state funds in the account.” The primary financial incentive provided to program enrollees is the ability to roll unused deductible funds into the My Rewards Account, which can be used to obtain certain services not covered by the Kentucky HEALTH program (such as vision and dental care, or gym memberships). **But providing a Kentucky HEALTH enrollee with diabetes a financial incentive to *not* use medical services—and therefore have a remaining balance in the deductible account at the end of the year—is counter-intuitive, and could result in increased costs for state and federal healthcare programs in the long-term.** For example, studies show intensive diabetes management can delay the onset and progression of diabetic nephropathy, which is the leading cause of end stage renal disease.¹⁰ Further, the most frequent reason for hospitalization of Kentucky Medicaid members was diabetic ketoacidosis (DKA), which also accounts for the largest total expenditure for diabetes-specific hospitalizations.¹¹ DKA is caused by a lack of insulin in the body. Unfortunately, low-income individuals have more DKA episodes

than others, likely due to an inability to afford medications.¹² If a low-income individual with diabetes is enrolled in the Kentucky HEALTH program, the financial incentive offered by the program may dissuade him from obtaining the medical care, supplies and medications he needs to manage his diabetes. This type of financial “incentive” is counter-intuitive and could potentially be harmful in the long-term to program enrollees with diabetes.

In addition to the potential long-term clinical impacts which could result from the inappropriate incentives offered through the Kentucky HEALTH program, the Association is also concerned the program does not meet the requirements of the ACA as it relates to the new adult eligibility group. We are particularly concerned the Kentucky HEALTH program incentive scheme violates Section 1302 of the ACA which says that in defining the Essential Health Benefits (EHB) the Secretary of the Department of Health and Human Services shall “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”¹³ Section 2001 of the ACA requires states to provide beneficiaries in the new adult group benchmark or benchmark equivalent coverage (called an alternative benefit plan or ABP), as outlined in Section 1937 of the Social Security Act.¹⁴ The ACA also modified the requirements of Section 1937 to require benchmark benefits to include at least EHB.¹⁵ Therefore, individuals in the new adult eligibility group must receive Section 1937 ABP coverage which includes EHB.

While it appears the benefits package for the new adult eligibility group outlined in the Kentucky HEALTH waiver application may meet the Section 1937 requirement of covering benefits in the ten EHB categories, the incentive program discriminates against individuals with disabilities—including those with diabetes—in violation of Section 1302 of the ACA. Program enrollees who have diabetes need regular medical care to treat and manage their disease, which puts them at a great disadvantage in achieving the offered incentive—rolling over unused funds from the deductible account to the My Rewards Account to purchase “enhanced” benefits—compared to program enrollees who do not have diabetes. **As such, the Association recommends CMS ensures all Kentucky HEALTH eligible enrollees with diabetes and other chronic conditions—not just those deemed medically frail—can access a coverage option that encourages and supports the use of necessary medical care, supplies and medications.**

The Option for Individuals Exempt from Mandatory ABP Enrollment is Inadequate

As discussed above, individuals in the new adult eligibility group are to receive Section 1937 ABP coverage.¹⁶ However, certain individuals in the new adult eligibility group “must be given the option of an ABP that includes all benefits available under the approved state plan.”¹⁷ This exemption includes individuals who are deemed “medically frail” by the state, the definition of which must at least include individuals with “serious and complex medical conditions.”¹⁸ The state seems to be proposing to enroll those deemed medically frail in the Kentucky HEALTH program, but will provide them with state plan benefits. Under this proposal, it appears an individual with a serious and complex medical condition will be enrolled in plan under which he will be told if he is “prudent” with the medical care he uses, he can receive money to pay for additional health benefits next year. As discussed above, diabetes is a

complex, chronic illness requiring continuous medical care. As such, the program offered to those exempt from mandatory enrollment in the ABP is not appropriate for someone with a serious and complex medical condition, such as diabetes. Further, the Kentucky HEALTH proposal does not actually include an “option” to those deemed medically frail—they are enrolled in Kentucky HEALTH, and if they voluntarily choose to pay monthly premiums they may be provided with additional benefits. This appears to violate the ACA requirements for individuals in the new adult eligibility group deemed medically frail. **The Association strongly urges CMS to instead allow those exempt from mandatory enrollment in the ABP to choose between the Kentucky HEALTH program, and a traditional state plan benefit program.**

Summary

The Association is pleased Kentucky has decided to continue to accept federal Medicaid funding to extend eligibility for its Medicaid program. Kentucky’s uninsured rate for the nonelderly fell from 18.8% in 2013 to 6.8% in 2015, one of the largest reductions in the country.¹⁹ It would be a great disservice to Kentucky residents if these proposed changes undo the excellent work the state has done to ensure every resident of Kentucky has access to adequate, affordable health care.

Unfortunately, the program outlined in the Kentucky HEALTH waiver application is not “likely to assist in promoting the objectives” of the Medicaid program as required in Section 1115 of the Social Security Act.²⁰ Specifically, the state’s waiver application shows a decrease in participation amounting to about 56,000 adults over the 5-year period of the demonstration project. In addition, the proposed incentives are potentially detrimental to the health of Kentucky HEALTH program enrollees with chronic health conditions, such as diabetes. Further, the Kentucky HEALTH incentive program discriminates against individuals with diabetes, and the program does not provide a program or benefit choice for individuals in the new adult eligibility group who are exempt from mandatory enrollment in the ABP. Finally, the cost-sharing requirements in Kentucky HEALTH are likely to deter individuals from obtaining Medicaid coverage and from accessing necessary care. **As such, the Association urges CMS to ensure Kentucky’s Medicaid program continues to meet the needs of all those eligible—regardless of income or medical need.**

Thank you for the opportunity to provide input on the proposed Kentucky HEALTH Medicaid Section 1115 waiver. Should you have any questions on the comments or recommendations we provided, please contact me at (703) 299-5528 or lmciver@diabetes.org.

Sincerely,



LaShawn McIver

Vice President, Public Policy and Strategic Alliances
American Diabetes Association

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- ¹ Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.
- ² Centers for Disease Control and Prevention, U.S. Diabetes Surveillance Data, 2014. Available at: <http://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#>.
- ³ 2015 Kentucky Diabetes Report, Department for Public Health, Department of Medicaid Services, Office of Health Policy, and Kentucky Employee Health Plan, Report to Legislative Research Commission on Diabetes, January 2015. Available at: <http://chfs.ky.gov/NR/rdonlyres/7D367886-671C-435E-BCF4-B2A740438699/0/2015DiabetesReportFinal.pdf>.
- ⁴ 2015 Kentucky Diabetes Report.
- ⁵ 2015 Kentucky Diabetes Report.
- ⁶ Centers for Disease Control and Prevention, 2014 National Diabetes Statistics Report. Available at: <http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html>.
- ⁷ Stevens CD, Schriger DL, Raffetto B, et al., Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California, 8 Health Affairs 33, August 2014.
- ⁸ Abdus S, Hudson J, Hill SC, Selden TM, Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.
- ⁹ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013.
- ¹⁰ American Diabetes Association, Standards of Medical Care in Diabetes—2014, Diabetes Care, S43, January 2014. Available at http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract
- ¹¹ 2015 Kentucky Diabetes Report.
- ¹² Gebel E, How to Avoid DKA, Diabetes Forecast, March 2013. Available at: <http://www.diabetesforecast.org/2013/mar/how-to-avoid-dka.html?loc=morefrom>.
- ¹³ Patient Protection and Affordable Care Act, Public Law 111-148, §1302(b)(4)(B), March 23, 2010. Note: Through rulemaking the Secretary allowed states to define EHB through a benchmark plan process.
- ¹⁴ P.L. 111-148 at § 2001(a)(2)(A).
- ¹⁵ P.L. 111-148 at § 2001(c)(3).
- ¹⁶ P.L. 111-148 at § 2001(a)(2)(A).
- ¹⁷ 42 C.F.R. § 440.315.
- ¹⁸ 42 C.F.R. § 440.315(f).
- ¹⁹ Cohen RA, Martinez ME, Zammitti EP, Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey 2013, and Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey 2015, Division of Health Interview Statistics, National Center for Health Statistics. Available at: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf> and <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201406.pdf>.
- ²⁰ 42 U.S.C. § 1315(a).